Dr Jawed Hamid

Alexandra Lodge Care Centre

Inspection report

355-357 Wilbraham Road
Chorlton
Manchester
Greater Manchester
M16 8NP

Tel: 01618605400

Date of inspection visit:
08 January 2018
09 January 2018
16 January 2018

Date of publication:
13 March 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 08 and 09 January 2018 and was completed on 16 January 2018 when a medicines inspector from CQC carried out an unannounced comprehensive inspection of medicines. At our previous inspection on 24 and 25 May 2016 the service was given an overall rating of requires improvement and we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, safeguarding, staffing, person-centred care (two parts) and good governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the overall rating of the service. At this inspection we found although the provider had taken action to improve the rating of some domains inspected, further improvements were still necessary in order to fully meet all regulatory requirements.

Alexandra Lodge Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Alexandra Lodge Care Centre provides nursing and residential care. The home is a detached property in its' own grounds and there is a designated car park. The home is located on a main residential road in Chorlton and is well positioned for local amenities and public transport to Manchester City Centre.

There are seven bedrooms on the ground floor, six of which are en-suite. The remaining 28 bedrooms are on the first floor, 14 of them being en-suite. Two of those can be shared by two people. Downstairs there are two lounges and two dining rooms. There is an enclosed garden and a nurses' office next to the main lounge.

The care home is registered with CQC to provide care and accommodation for up to 37 people and at the time of inspection 31 people were living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living at Alexandra Lodge Care Centre told us they felt safe and said staff were kind and caring. The staff we spoke with told us they had completed training in safeguarding and were able to describe the different types of abuse that could occur.

There were policies and procedures to guide staff about how to safeguard people from the risk of abuse or harm. Staff had access to a wide range of policies and procedures regarding all aspects of the service.

Staff received appropriate induction, training, supervision and appraisal and there was a staff training matrix in place. Staff told us they had sufficient induction and training and this enabled them to feel confident when supporting people.

We saw there were individualised risk assessments in place to identify specific areas of concern. The care plans were person-centred and covered essential elements of people's needs and preferences. Staff sought consent from people before providing support. People's health needs were managed effectively and there was evidence of professional's involvement. Information on how to thicken drinks was not always available in people's care files but was in the kitchen and one staff member gave the wrong amount of thickener.

Equipment used by the home was maintained and serviced at regular intervals. The home was clean throughout and there were no malodours. The environment was suitable for people's needs.

We looked at five staff personnel files and there was evidence of robust and safe recruitment procedures.

Accidents and incidents were recorded and audited monthly to identify any trends or re-occurrences. The home had been responsive in referring people to other services when there were concerns about their health.

People told us the food at the home was good. There was a four week seasonal menu in use and this was displayed on the wall in the dining room. We found people's nutritional needs were monitored and met.

People told us staff treated them well and respected their privacy and dignity. We observed positive interactions between staff and people who used the service.

When people had undertaken an activity this was recorded in their care file information and there was a range of activities available for people to choose from.

The service aimed to embed equality and human rights though good person-centred care planning and people were provided with a range of useful information about the home and other supporting organisations.

Personal evacuation plans were in place but would benefit from more added detail about each person.

The service was supported by other relevant professionals when providing end of life care and feedback received from a visiting health care professional about end of life care was very positive. The home had a good working relationship with a local GP practice and was experienced in caring for people who were nearing the end of life which enabled people to stay in the home if they wished. Several relatives had commended the home for the quality of its end of life care provision.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with aspects of their care. There was a service user guide and statement of purpose in place.

The home had received a high number of compliments since the date of the last inspection. Formal feedback from staff, people who used the service and their relatives was sought through annual quality assurance surveys.

Regular audits were carried out in a number of areas but had not always been effective in identifying and

resolving some of the issues we found with medicines and drink thickeners, which was a breach of regulations.

The service worked in partnership with other professionals and agencies in order to meet people's care needs.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. We saw the last CQC report was also displayed in the premises as per legal requirements. Shortly after the date of the inspection the registered manager contacted us to identify their website had been removed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they felt safe living at the home.

Medicines were not always managed safely.

There were safe procedures for the recruitment of staff and sufficient numbers of staff on duty.

Is the service effective?

Good

The service was effective

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times.

Care plans included appropriate personal and health information and were up to date.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us staff were kind and caring.

Staff attitude to people was polite and respectful and people responded well to staff interactions.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were up to date and contained relevant information.

Care plans were person-centred, well organised and easy to follow.

Positive comments were received regarding the provision of end of life care.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits which were carried out regularly had not identified the concerns we found in relation to medicines and drink thickeners.

Staff felt the home was well-led and told us the registered manager supported them well.

People were asked for their views about the service and the culture of the service was focussed on the needs of people who used the service.

Alexandra Lodge Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 08, 09 and 16 January 2018. The first day was unannounced which meant the provider did not know we were inspecting on this day. The second day was by arrangement. We returned for a third day of inspection on16 January 2018 specifically to look at the safe management of medicines.

The inspection team consisted of one adult social care inspector, a CQC pharmacist inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. On this occasion the expert by experience had personal experience of supporting older people living with dementia in a residential, community and acute care setting.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us under the regulations.

During the inspection we looked around the building and observed mealtimes and interaction between staff and people living in the home.

We spoke with 11 people using the service, two visiting relatives, six members of staff, and two visiting

professionals. We also spoke with the registered manager and the provider.

We looked at six care records in detail, medicine administration records for 16 people, five staff files, and staff rotas for four weeks. Following the inspection the registered manager sent us a number of documents at our request, including their business renovation plan, service user guide and statement of purpose.

Requires Improvement

Is the service safe?

Our findings

We asked people living at Alexandra Lodge Care Centre if they felt safe. One person said, "I've been here about 7 months it's okay I'm just passing time here." A second told us, "No I'm not frightened or worried about anything; I feel safe enough." A third commented, "I get my medication on time thank you." A fourth person stated, "I am happy here; it's quite acceptable."

A visiting relative told us, [My relative] has been here 12 months and was at two other places before this one and this is by far the best because there are nurses here if [my relative] needs them. I am confident that [my relative] is being well looked after here and as you can see [my relative] looks pretty healthy."

At our last inspection on 24 and 25 May 2016 we found the home was in breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always administered safely or kept securely. At this inspection we found although improvements had been made regarding the safe management of medicines, further improvements were still needed to meet the requirements of this regulation.

We asked staff if they had undertaken training in medicines management. One staff member said, "I did medication training three months ago; the nurse does competency checks on us every day; the nurse always checks the paperwork after we do it. If I thought there was a medication error I would report it to the clinical lead or the nurse."

We watched the nurse and senior carer give people their medicines in the morning and at lunchtime. We saw they administered medicines in a friendly way and signed the medication administration record (MAR) after giving each person's medicines. People were given their morning medicines when they chose to get up. However at lunchtime the nurse was about to give one person a medicine too soon after their morning dose until we queried this with them. The right length of time must be left between doses of this particular medicine to keep people safe from harm.

We looked at the MARs belonging to 16 of the 32 people living in the home. There were no 'gaps' in the administration records. Records were kept to account for medicines and liquid medicines were dated when the bottle was first opened.

A list of people who needed thickened drinks because they had swallowing difficulties was available and the use of thickening agents was recorded on people's MARs. Each person's care records did not always state the amount of thickening agent added to people's drinks to confirm they had been made to the right consistency, although we did see information on how to make up different diet and fluid types was posted in the kitchen. If a person's drink is not thickened in the right way there is a risk they could choke.

We saw a carer make one person's drink thicker than the consistency stated in their care plan or on the handover sheet and we were told that these records had not been updated. We brought this to the attention of the registered manager who told us they would take immediate action to ensure staff had the correct

information regarding thickening drinks. We found thickening agents were stored safely.

Some people were prescribed a mild painkiller to be taken 'when required'. There was no extra information (in the form of a protocol) for each person telling staff how to decide if they needed the medicine and the type or site of pain for which it was prescribed. Six people prescribed a painkiller 'when required' were being given the medicine regularly four times a day. The pharmacy had supplied the tablets in a bubble pack with their other, regular medicines. This could result in staff giving pain relief tablets inappropriately or in an unsafe way.

We noticed that most moisturising and barrier creams were labelled "use as directed" by the pharmacy. We asked the manager to make sure staff had the information necessary to apply these prescribed creams in the way the doctor intended.

Medicines were kept at the right temperatures. The temperatures in the rooms and refrigerator where medicines were stored were monitored in the right way. Medicines were stored inside locked rooms and cupboards. We asked the manager to risk assess the level of security provided by the door lock for one room. We found that one medicine that was a controlled drug (a medicine subject to tighter controls because it is liable to misuse) was not stored in the way required by law.
Nurses checked stocks of controlled drugs (CDs) twice a day. We checked a sample of five CDs and found that stock balances were correct. When looking at the CD register we saw that one recording error had been corrected by writing over the number. When corrections are made in CD registers the original record must be legible, to prevent mishandling.

The home's medicine policy was available for staff to read. The home had two oxygen cylinders for emergency use. There was no system of regular checks and no protocol for the use of oxygen in an emergency.

These issues meant there was a continued breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider was failing to protect people against the risks associated with the unsafe use of medicines. You can see what action we told the provider to make at the back of the full version of this report.

At the last inspection, the failure to identify incidents of abuse and alleged abuse and to report them appropriately to the local safeguarding authority was a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the service had taken the necessary remedial action and was now meeting the requirements of this regulation; there was now a robust procedure in place to ensure incidents of abuse or alleged abuse were reported to the local authority as required.

A comprehensive log of all safeguarding referrals was kept including the reference number, nature of incident, date and time, name of person raising the alert, name of the local authority designated officer, the date the associated statutory notification was sent to CQC and the dates of any associated meetings with professionals or relatives.

There were policies and procedures to guide staff about how to safeguard people from the risk of abuse or harm. We looked at the safeguarding policies and procedures which were clear and up to date. We saw from records that staff had completed training in safeguarding. Staff we spoke with confirmed they had received training in safeguarding and were aware of the actions to take if they had any concerns such as informing the manager, the local authority and CQC.

Similarly staff were aware of the whistleblowing procedure, designed to enable them to raise any concerns in a confidential way. One staff member said, "I have done safeguarding training. Signs of abuse would be marks, reactions, changes in behaviour, fear, aggression. I keep people safe by watching in case they wander off, checking what they eat, keeping them tidy, keeping rooms and corridors free of hazards, keeping thickener and creams out of their reach." A second staff member told us, "Signs of abuse would be bruising, disclosure, actually seeing it, erratic behaviour. I keep people safe by making sure they are sat properly in their wheelchair, keeping their feet on footplates, using their own walking aids, keeping the front door locked." A third stated, "Signs of abuse would be if people appear scared, timid, bruised, withdrawn or if they are different with one carer than others."

We saw there were individual risk assessments in people's care files and care plans identified specific areas of concern and how these were managed such as; falls, skin integrity, nutrition, choking, moving and handling. This helped ensure guidance was in place for staff on minimising risks to people's wellbeing and safety. The risk assessments were reviewed and updated when changes occurred.

People had personal emergency evacuation plans (PEEPs) which detailed each resident, which room they were in, what their daytime/ night time mobility was and the equipment needed, how many staff members were needed for each person and which local authority was funding them. A copy of this was kept on a wall on each of the floors of the building. However there were no specific details of which evacuation route to take, if the person had any difficulties understanding instructions and their medical conditions/history. We found PEEPS needed to be more detailed and consideration needed to be given to the provision of a 'grab file' to contain all information in one easily accessible place. We informed the registered manager of this who told us information would be updated.

At the last inspection the high use of agency staff and the excessive hours worked by some staff indicated a lack of staff availability which was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked staffing levels to ensure there were enough on duty to safely meet people's needs. Staffing levels corresponded with the rotas we were provided with and no agency staff were now used which meant staff were familiar with the people they supported. We looked at rotas for a four week period. During most of the day there was one nurse or a clinical manager who was also a nurse and six care workers on duty in addition to the registered manager. These were supported by ancillary staff such as domestic, kitchen, maintenance and laundry staff. At night there was one nurse and three care workers on duty. When calculating staffing levels the provider used a formal dependency tool which calculated the required amount of staff needed during the morning, afternoon and night. We saw the actual number of staffing hours provided was greater than the required number of hours identified in the dependency tool.

We asked staff if they felt there were sufficient numbers on duty. One staff member said, "We do have enough time for everyone, we have around three hours to get everyone up which is approximately 30 minutes per person but it depends on their needs." A second told us, "We do have enough time for each resident, even in the mornings we have enough time." A third commented, "We are normally given enough time to help each resident properly, unless the night staff haven't done their job properly, then it's harder in the mornings." A visiting relative commented, "I come every day so I can see how good the staff are with [my relative]. The staff are outstanding they can't do enough for [my relative].

We looked at the process of staff recruitment and looked at five staff personnel files and found staff were recruited safely. Files contained application forms including contact numbers, National Insurance number, a medical questionnaire, education history, employment history, proof of identify and address, two

references, documented interview notes, Disclosure and Barring Service (DBS) certificates, contract of employment and a confidentiality agreement. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. This demonstrated the manager had followed safe staff recruitment practices.

We found the registered manager held discussions with staff if an issue about their conduct arose and this was in accordance with the disciplinary process. We saw records of discussions about staff attitude and approach to people who used the service, which if continued would lead to disciplinary action. We found confidential discussion documents relating to disciplinary issues had been hand delivered to the staff member concerned and this demonstrated the manager addressed any issues raised in a prompt and efficient way.

Environmental risk assessments and audits were in place to ensure a safe environment and ensure the protection of people using the service, their visitors and staff from any injury caused by faulty or poorly maintained areas. We saw evidence of safety and maintenance checks on the lift and hoists/slings, gas appliances and electrical appliances. The fire alarm system, fire detection system, and fire extinguishers were routinely serviced and fire evacuation drills were undertaken approximately every three months. Up to date certificates were in place for gas safety, electrical wiring, the passenger lift, mobile and fixed hoists and slings. Water temperature checks were undertaken regularly and there was an up to date Legionella risk assessment and samples report. There was a business contingency plan in place which provided guidance in the event of an unexpected occurrence such as fire or flood, loss of staff, accommodation loss, catering disruption, loss of utility supplies, lift breakdown and severe weather.

The premises were clean throughout and free from mal-odours and we observed domestic staff undertaking cleaning activity in all areas of the home. The staff followed the 'national colour coding scheme' for cleaning materials and equipment and cleaning schedules were completed and up to date. Chemicals were stored safely and information on how to use hazardous chemicals (COSHH) was available to staff.

During the inspection Manchester City Council undertook an environmental health inspection in the kitchen and associated areas and the provider had achieved the highest possible score of five with only minor improvements identified. A recent infection control audit had been carried out in December 2017 and the home had achieved a score of 80% compliance against a set of 16 critical standards. Any remedial action necessary was identified in an action plan which identified the action required, the person responsible, the date to be resolved and the date completed.

Accidents and incidents were recorded and audited monthly to identify any trends or re-occurrences. Where appropriate these contained an associated body map to identify the specific site of the injury and identified the action to be taken to reduce the potential for further re-occurrence in the future. The accident/incident file was comprehensive and included month-by-month information.

Audits documented the number of incidents per month, whether they were daytime/ evening or night time, if any serious injury had been sustained, and if any person had suffered three or more accidents or repeated falls. Each accident/ incident had a report form including a detailed description, date, actions taken, risk assessment needed, care plan reviewed/ amended, social worker informed or not, if any medical advice sought. Each accident/ incident was investigated, reviewed and signed by the registered manager. CQC statutory notifications were detailed in the file, and we found incidents had reported to CQC as required.

Good

Is the service effective?

Our findings

We asked people who used the service if they felt staff had the correct skills and knowledge to provide effective care. One person said, "Some of the staff are wonderful, it's just the odd one I don't get on with and some of the ones who come when people are off don't know what they are doing and I have to tell them what I want." The relative of this person told us, "I think they are all very good at their jobs and they look after [my relative] very well; I only live round the corner so it's a doctor from our old practice that comes round so that's great." Another relative stated, "They have referred [my relative] on for further assessments already and she's only been here three months; they are on the ball."

Another visiting relative commented, "They are good here; they are busy but very good. [My relative] is very safe and very happy and we have no concerns at all; my wife or I come most days. My wife had one minor concern at the start about [my relative's] laundry but she spoke to [manager name] and it was sorted immediately; they keep [my relative's] belongings safe."

We observed a written instruction to staff on one person's bedroom door that identified the frequency of repositioning 'turns' the person required during the night and the amount of time the person must be left undisturbed in order to sleep properly in between periods of pressure care relief. There was also written instruction from the relative of this person regarding the management of their hearing aids. This showed us the service had included relevant people in determining this person's needs in order to deliver an effective outcome.

We looked at staff training and saw there was a staff training matrix in place. We saw staff had access to a range of training including MCA/DoLS, first aid, fire safety, food hygiene, safeguarding, infection control, health and safety, moving and handling, nutrition and diet, person centred care planning, pressure care, catheterisation, diabetes, Alzheimer's and dementia, end of life care and challenging behaviour. Staff we spoke with confirmed they had completed this training which we also verified by looking at historical training records held by the service.

Staff were required to complete a programme of induction as part of their probationary period, which was followed by an observed practical assessment before confirmation in their role. Staff were also required to familiarise themselves with the people using the service by reading care plans and spending time in their company. If a new staff member had not previously worked in social care, induction was aligned with the requirements of the care certificate. One staff member said, "My induction was easy as I had already worked in this home for an agency but [manager name] went through everything again and it took three days." A second staff member told us, "I did induction over three days and also shadowing other staff; I was an experienced carer when I came here."

We found staff received supervision every two months. We looked at the staff supervision file, completed by the registered manager and saw each supervision record was different which demonstrated the registered manager tailored the supervision to the individual staff member's needs. Each supervision identified different areas to be addressed and where issues were identified by staff there was advice about how to

address them from the manager. Annual appraisals were undertaken for each staff member and these discussed strengths, weaknesses and achievements, and had action plans which were all documented.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There were appropriate records maintained relating to people who were currently subject to DoLS. There were appropriate mental capacity assessments in place which outlined the issues and concerns. Timely applications for DoLS had been made when the indication was this was required and we saw these were up to date and reviewed regularly.

We saw no evidence that people were being deprived of their liberty without authorisation. Applications for DoLS authorisations had been made and in some cases authorised (although others were still awaiting a decision). Those applications we saw had been completed correctly and set out the reasons for the application. The outcome of applications had been notified to CQC, as required under the regulations. A tracker file was kept with information for each person which allowed the service to adequately monitor any applications and their outcomes.

We found seventy percent of care staff had received training in MCA/DoLS and further training was planned for the remaining staff. The staff we spoke with were able to explain why people may be deprived of their liberty. One member of staff said, "MCA is about protecting vulnerable people who can't make decisions on their own and others make decisions in their best interest; I always think how I would feel in their position." A second staff member told us, "MCA/DoLS is when people can't make decisions for themselves and their needs and preferences still need to be met." A third stated, "MCA is when residents can't decide for themselves and a best interest decision needs to be made for them." DoLS is when they can't leave the home on their own."

We looked at the mealtime experience and saw staff supported people with patience and consideration, holding conversations with people as they supported them at mealtimes. The meal times were not rushed and people had plenty of time to eat their meal at their own pace. There was as seasonal menu in use which was balanced and offered a good range of choices and included 'themed' weeks such as Asian, Chinese and West Indian. We saw dining tables were nicely presented with a menu, napkins, place mats, cutlery and drinks.

There was information on food allergens and eating and drinking guidelines for each person if they required a specialist or modified diet or thickened fluids. There was NHS information for staff on recognising the signs of reduced motivation to eat and drink which assisted staff to recognise if a person had changed their eating habits.

We asked people about their opinions of the food provided. One person said, "The food is first class and I eat most of it." A second person said, "The food is beautiful, I have to have it pureed but it's very nice." A visiting relative commented, "The food is fine and the staff prepare [my relative's] food at lunch time and I come in

to help feed her which I like doing; they are marvellous."

We also spoke with a visiting nutritionist about the management of people's diets; they told us, "All documentation is at it should be. Staff are competent and I'm happy that diets are being managed properly, for example I have not known anyone to have had an infection as a result of poor fluid intake."

Food temperatures were checked and recorded at each serving. We checked the food stocks in the kitchen and found there was an adequate supply of fresh and dry goods and the freezers were well stocked. Fridge temperatures were recorded daily and a daily and weekly cleaning schedule was in place. The environmental health officer food hygiene rating score (FHRS) was five; food preparation facilities are given an FHRS rating from zero to five, zero being the worst and five being the best. There was a food hygiene policy and we saw that staff had completed training in food hygiene.

We found people's nutritional needs were monitored and met. People's nutritional status was assessed as part of the admission process and risk screening was carried out using a nationally recognised tool. We saw any risks identified were recorded in care plans and people were weighed as required. People's weights were regularly monitored and action taken if staff were concerned about any significant weight loss.

People's health needs were managed effectively and there was evidence of professional involvement, for example GPs, podiatrists, district nurses, Speech and Language Therapy (SaLT), dietetic advice, chiropodists or opticians where appropriate. This demonstrated people had access to health care professionals when required. Staff recorded in each person's care file when they had been visited and treated by health care professionals.

The environment was suitable for people's physical needs. There were hand rails in corridors, grab rails in toilets and bathrooms, pressure relieving items and sufficient moving and handling equipment. There was some signage for bathrooms/toilets, the dining room and other areas of the building which would assist people living with a dementia to better orientate around the building. We noted some flaking paint or chipped plaster in various areas of the home; however we saw the service had a refurbishment plan for 2017/18 which included redecoration and the replacement of carpets and furniture.

People were able to personalise their bedrooms with individual items such as family photographs, bedding and personal objects and there was adequate space and seating in each bedroom for visitors to use and spend private time with their relative.

Good

Is the service caring?

Our findings

When we last inspected this service on 24 and 25 May 2016 we found the home was in breach of Regulation 9 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care. This was because feedback received from a relevant healthcare professional identified continence issues were not always managed properly and there was a risk of skin deterioration and moisture lesions developing. At this inspection we found the provider had taken remedial action necessary and the home was now meeting the requirements of this regulation.

During the inspection we spoke with a visiting district nurse who told us, "I get a call or a fax if there is a problem; no-one has got worse and I provide advice for the staff to follow but they need to be pro-active in responding to instruction."

We asked people and their relatives if they felt staff were caring. One relative said, "They are very caring. [My relative] loves it here, she's happy again. They [staff] are always approachable, even when they are busy. [My relative] can't be too independent as she kept falling at home but they encourage her to walk, she does the things that she can do and they help her with the things she can't do." We observed when this relative arrived at lunchtime they were welcomed in by staff and asked if they would like to have dinner with [their relative]; they declined and waited outside the dining room. The relative knew all the staff by name and had friendly interactions with them and other residents.

We asked people if staff promoted their independence. Comments from people who used the service included, "All I can say is that they look after me," "The girls who look after me in the main are great; I am dead happy here I do a lot of knitting, "They have to use a hoist and put me on a chair because I can't walk. They wash me and I have no complaints, they help me, it's okay," "They do all my personal care, shower and help me dress I have no complaints about how they treat me and my daughter is happy that I am here," "I've been here six months and the staff are lovely and friendly and they look after me well; I'm safer than at home."

However one person told us they thought night staff were using some of their personal pads for other people. We spoke with the registered manager about this comment, who was unaware of the situation but told us they would investigate immediately. This person also told us staff sometimes took a while to respond when they pressed their nurse-call bell. We tested staff response by pressing the bell and found staff arrived within two minutes.

We found the principles of a caring service had now become key indicators of staff performance, assessed once every three months via formal supervision sessions. Any member of staff whose performance (as rated by people who used the service) fell below an acceptable level would have their performance managed via mentoring, training or disciplinary action as appropriate. It was also the intention of the provider to introduce a 'care champion' for each person using the service who would be a named member of staff responsible for ensuring that the people received a service that they would describe as caring.

We asked staff how they demonstrated a caring approach and treated people with dignity and respect. One staff member said, "One person tells us to go away so I try to talk calmly to him but will go away if he insists, I will go back later and usually he has calmed down by then. I would also ask for support from my colleagues." A second staff member said, "I always knock before I go into a room and always gain verbal consent before personal care. If they refuse I try to persuade them in a friendly way but if they still refuse I respect their wishes." A third commented, "When people can't communicate verbally I use sign language and show them items like a cup for a drink or a plate for dinner and I ask them what they would like to wear." A fourth stated, "I respect people's dignity and privacy; I am always discreet when asking them if they need to go to the toilet and I always keep their doors closed when helping with personal care."

Throughout the inspection we overheard lots of laughter and conversation between staff and people and staff took their time to speak to people individually, for example when asking what they wanted to eat or if they wanted to take part in activities. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service. Staff were patient and spoke to people in a kind way.

We found people's care files were held in the office where they were accessible but secure and staff records were also held securely in lockable cupboards. Medication administration records were stored in the lockable treatment room. Any computers were password protected to aid security.

We saw people were provided with information about the service. There were notice boards to indicate which activities were to be carried out each day. There were leaflets in reception about the service, how to complain and advocacy arrangements.

There was information about likes, dislikes and preferences in care files for how care should be carried out which demonstrated people and their relatives had been involved in decisions about planning their care and support.

The previous inspection report was on display in the home along with a range of other useful information for people who may be considering a placement in the home. Each person was provided with a 'service user guide' which included information about the service and staff and how to make a complaint. The guide included reference to a 'service user's charter' which identified the values of the service based on the rights of fulfilment, dignity, autonomy, individuality, esteem, a high quality of life, freedom of emotional expression and the right to take risks. A statement of purpose was also provided to people which is a legally required document that includes a standard set of information about a provider's service.

We looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs. For example when one person had been referred to the home who required a halal diet the service had responded by ensuring there was a separate food preparation area and utensils for this, as required.

We found there were appropriate policies in place which covered areas such as equality and diversity, confidentiality, privacy and dignity.

Good

Is the service responsive?

Our findings

We asked staff what they understood about person-centred care. One staff member said, "Person centred care is knowing everyone has different needs and preferences and we meet them, so if someone needed pain relief, they would tell me or their body language or facial expression would show me and I would tell the nurse." A second told us, "Person centred care is what we do to meet the needs and preferences for each person." A third staff member commented, "If people have dementia, I listen to them, I don't correct them, they repeat themselves so I repeat my answers. I agree with them if they say it's a different date, I don't upset them." A fourth said, "Person centred care is care that is specific for that person."

At the last inspection the service on 24 and 25 May 2016 we considered the failure to promptly address the loss of the hearing aid had adversely affected one person's quality of life and there was a failure to ensure their pressure cushion was plugged in, which was a breach of Regulation 9(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

At this inspection people told us their health care needs were met and there was no-one who did not have the correct pressure cushion in place. Each care plan contained a variety of risk assessments and included areas such as nutrition, mobility, skin care, physical health, mental health and pain management. The plans contained a profile of the person concerned which was completed for every person. Care plans were kept up to date and were easy to follow.

We found the home had been responsive in referring people to other services when there were concerns about their health. For example, people with swallowing difficulties had been referred to Speech and Language Therapy team (SALT) and provided with an appropriate diet type following their assessment and daily records were kept of any staff observations and interactions with people to ensure guidance was being followed.

Care plans contained a good level of detail and had a person centred approach. We saw prior to admission the provider completed their own initial assessment to determine that the home was able to meet the person's support needs. Some people also had additional assessment information received prior to admission from the referring local authority. This enabled staff to establish what people's care needs were and the type of individual care people required and the involvement of people and their relatives was recorded in their care file information.

At the time of the inspection there was no person living at the home that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010. We found no evidence to suggest that anyone who used the service was discriminated against and no one we spoke with contradicted this. We saw as part of the home's initial assessment people were asked about any particular religious observances they required support to keep. Some people had indicated they would like to attend church or attend a religious service and this was supported. This meant people's diversity was protected and supported.

Care files contained a document called 'This is Me' which is a document for anyone receiving professional

care who is living with dementia or experiencing delirium or other communication difficulties and provides a support tool to enable to provision of person-centred care. We saw the forms included details on the person's cultural and family background; events, people and places from their lives; preferences, routines and their personality. This enabled staff to see the person as an individual and deliver person-centred care that was tailored specifically to the person's needs.

The home employed an activities coordinator and activities on offer were displayed around the premises. We spoke with the activities coordinator who told us, "We have set activities and they are the same every week. Each person chooses to do the activity or not and activities are designed around what we can do. When it's warmer outside I will take people out to the park. I introduced new music which was my idea and I note down if people don't engage in the activity.
We saw activities included shopping, hand massage and nails, exercises, baking, games, arts and crafts, films, bingo, hairdresser and family time.

We saw in people's care plans there were details about their individual interests such as previous hobbies and experiences, favourite television programmes and books. Most of the people we spoke with said they no longer pursued their interests but instead watched television or were visited by their family. However people told us staff did encourage them to take part in activities but respected their choices and we saw this was recorded in their notes.

We asked people if they felt there were enough activities on offer. One person said, "I like to stay in my room most of the time because I like watching ice hockey and American football on the telly. I get everything I need I don't want anything changing." A second person told us, "I am dead happy here; I like to do a lot of knitting and sit in the lounge and look out of the window on to the garden." A third person commented, "I don't take part in any activities and I stay in my room because there is no one to talk to down there. I have my TV and my Computer." The relative of this person stated, "There are some activities but [my relative] can't do much but they have singers come in now and again which I think she appreciates."

We looked at how complaints were managed and saw there had been three complaints received in the previous 12 months. All complaints had been investigated by the registered manager and statements taken from everyone involved. We saw all issues raised had been resolved with actions recorded and copies of letters sent to all parties kept in file. We found the management of complaints to be very thorough.

The home had received a high number of compliments since the date of the last inspection, particularly in relation to the provision of end of life (EOL) care. One compliment from the relative of a person who previously used the service stated, 'Alexandra Lodge is extremely well run with both [manager name] and [nurse name] at the forefront at all times coupled with dedicated and caring staff. The cleanliness, meals and even the entertainment is second to none and if I could award five stars I would. To let you know that the whole family is grateful to all the care, kindness and compassion and medical care that has given to [my relative] in her final days.'

The service was supported by other relevant professionals when providing EOL care and people's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Some people we spoke with living at the home confirmed this was the case. At the time of the inspection we were told there was no-one currently living at the home with end of life needs. Where relevant care files contained an 'advanced decision' regarding end of life wishes and 'do not resuscitate' forms (DNACPR) were in place where the person had made this decision.

We spoke with a visiting doctor about EOL care; they were very complimentary and told us, "Alexandra

Lodge is always organised; they have no negative feedback, only positive. They are competent at EOL care; they don't panic and phone 999 and they have been supported by the GP practice so are proactively referring where necessary. We have seen a reduction in hospital admissions and an increase in effective and caring EOL care provision. I always observe kindly interactions with residents and no signs of neglect or abuse."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, they are Registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we carried out an inspection of this service on 24 and 25 May 2016 although we were satisfied that the provider conducted a range of audits to monitor the quality of the service, these audits had not identified many of the issues identified during this inspection, or if they had, action had not been taken and this was a breach of Regulation 17(1) and 2(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

At this inspection we looked at the audits the registered manager had undertaken of key areas of care and record keeping. Audits included infection control, people's weights, care plans and care files, DoLS, daily walk-around of the premises including staffing levels cleanliness and resident's appearance, medicines, accidents/incidents and complaints. Weekly management meetings were held and any issues arising from the audits were discussed at these meetings which demonstrated an open culture of information sharing within the home.

A CQC statutory notifications file was also kept which included all the relevant information associated with the notification sent to us and our response. Notifications received included safeguarding, DoLS, deaths and injuries which showed the provider had submitted statutory notifications as required.

Although audits had been undertaken regularly they had not identified or rectified the issues we found regarding the management of people's medicines and this was a continuing breach of Regulation 17(1) and 2(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. You can see what action we told the provider to make at the back of the full version of this report.

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, whistleblowing, health and safety and infection control which were available to staff if they needed to seek advice or guidance in a particular area. There was a separate notice board for staff which included information on using equipment, safeguarding, consent to treatment, care workers duty of care, and MCA/DoLS which was useful for staff to refer to as a quick reference guide.

It was clear from our observations that the manager worked well with the staff team and was actively involved in supporting them throughout the inspection. We asked staff their opinions on management. One staff member told us, "[Manager name] is very fair, he always considers issues and he does meetings and we can put ideas forward, if it's good they embrace it. I can approach [manager name] and he always gives us positive feedback."

A second staff member said, "[Manager name and [nurse name] are very fair and [manager name] does

listen to me. I asked him if I could move a bed around as it was hard to get the hoist in the room and the residents legs could have been squashed against the wall; he agreed with me and we moved the bed. I don't like it when agency staff work here, they don't know the residents and they don't work hard. I told [manager name] and [nurse name] and they said they are trying to reduce the number of agency staff and trying to recruit new staff."

At the time of inspection we found no agency staff were being used which showed the provider and registered manager actively listened to the staff team and incorporated their views into daily care delivery.

Formal feedback from staff, people who used the service and their relatives was sought through annual quality assurances surveys. We looked at 17 questionnaires returned in 2017 and all were complimentary with no negative feedback.

There was a service user guide and statement of purpose in place. A statement of purpose is a document which includes a standard required set of information about a service. When people were given a copy of the service user guide at the commencement of their residence they were also given a copy of the complaints policy.

The service had a business continuity plan that was up to date and included details of the actions to be taken in the event of an unexpected event such as the loss of utilities supplies, fire, loss of IT, an infectious outbreak or flood. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support people using the service in a safe and co-ordinated way.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. We saw the last CQC report was also displayed in the premises and on the provider website as required. The website also provided a wide range of information that would be useful to people considering residence at the home and/or their relatives.

There was a notice posted in the home for people's relatives identifying the dates and times the registered manager was available for family discussions which meant people could plan a meeting in advance. In addition to these planned meetings, we found the manager was readily available at any time to speak to people or their relatives if they so wished which they confirmed. One relative said, "[Manager name] and [nurse name] are very approachable and contact me if they want to tell me anything about [my relative] like recently they rang to say she had a chest infection but I knew she was a bit off because I come every day." A person who used the service commented, "[Manager name] and [nurse name] are in charge and the owner's daughter is nice and they talk to me to see how I am doing."

We found the provider had achieved Investors in People (IIP) status in 2015 and this was still applicable and had not expired at the date of the inspection. Investors in People is the mark of high performance in business and people management and is underpinned by a rigorous assessment methodology.

The service worked in partnership other professionals and agencies for example, as the local authority, clinical commissioning group (CCG), district nurses, dieticians, podiatrists GP's and opticians in order to meet people's care needs as required and involvement with these services was recorded in people's care files. We asked people if they attended meetings with their relatives, one person told us, "They do have residents meetings and I can go to the office if I need to speak but I have no complaints." We saw regular meetings took place with people and their relatives, normally occurring every two months. We looked at records from previous meetings and discussion topics included the menu and food, care tasks, activities, safety and the environment.

Staff confirmed they held regular meetings with the registered manager. We saw notes from the previous four meetings and found discussions included health and safety, MCA, consent, infection control, teamwork, laundry, pressure relief, safeguarding, privacy and dignity.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring the proper and safe management of medicines. Regulation 12(1) and 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to effectively assess, monitor and improve the quality and safety of the services provided. Regulation 17(1)(2)(a)